Blue Cross Blue Shield of Michigan

Revised 2020 Hospital Pay-for-Performance Program (for peer groups 1 through 4)

Hospital CQI Performance Index Scorecards

2020 Revised CQI P4P Indices

Due to the Coronavirus pandemic, BCBSM/BCN asked the CQI programs to review and revise their P4P performance indices to ensure changes were made to accommodate the unique challenges faced this year. This document provides the updated performance index for each CQI. Each index is followed by a brief explanation of what changed.

The following CQIs made no changes at all to their P4P performance indices:

- Michigan Trauma Quality Improvement Program (MTQIP)
- Michigan Anticoagulation Quality Improvement Initiative (MAQI2)
- Michigan Society of Thoracic and Cardiovascular Surgery (MSTCVS)

CQI Program Manager Contacts

CQI	Clinical Focus Area	Index Scorecard Page	Project Manager	Phone	Email
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I-MPACT	Care Transitions	17	Pam James	734-615-9752	pajames@umich.edu
MAQI2	Anticoagulation	N/A- No revisions	Brian Haymart	734-998-5631	khaymart@umich.edu
MARCQI	Knee/Hip Arthroplasty	24	Tae Kim	734-998-0464	taekk@med.umich.edu
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MROQC	Radiation Oncology	35	Melissa Mietzel	734-936-1035	hillmel@umich.edu
MSSIC	Spine Surgery	37	Jamie Myers	313-874-1892	Jmyer8@hfhs.org
MSQC	General Surgery	40	Kathy Bishop	734-763-3717	bishopk@med.umich.edu
MSTCVS	Cardiac Surgery	N/A- No revisions	Patty Theurer	734-998-5918	ptheurer@umich.edu
MTQIP	Trauma Surgery	N/A- No revisions	Judy Mikhail	734-763-8227	jmikhail@umich.edu
OBI	Obstetrics	42	Nina Bobowski	734-232-2715	npbo@med.umich.edu

All ASPIRE Sites willwill receive full points for 2020 performance measures (measures 5, 6, & 7)

2020 Anesthesiology Performance Improvement and Reporting Exchange (ASPIRE)
Collaborative Quality Initiative Performance Index Scorecard
POST COVID-19 Updates
Cohort 1 - 4: 15 Sites (excludes Trinity sites)
Measurement Period: 01/01/2020 - 12/31/2020

Measure #	Weight	Measure Description	Points
1	10%	**Collaborative Meeting Participation: ASPIRE Quality Champion & Anesthesiology Clinical Quality Reviewer (ACQR) combined attendance at virtual collaborative meetings. Two total meetings w/four opportunities for attendance**	
		3 - 4 / 4 Virtual Meetings	10
		2 / 4 Virtual Meetings	5
		1 or Less Virtual Meetings	0
2	5%	**Attend Webex ASPIRE Quality Committee Meetings: ASPIRE Quality Champion or ACQR attendance across five meetings**	
		5 Meetings	5
		4 or less Meetings	0
3	5%	**ACQR/ASPIRE Quality Champion perform data validation, case validation and submit data by the third Wednesday of each month for January through November and by the second Wednesday of the month for December**	
		10 - 11/12 Months	5
		9 or Less Months	0
4	10%	**Site Based Quality Meetings: Sites to hold an onsite or virtual meetings following the two ASPIRE virtual collaborative meetings to discuss the data and plans for quality improvement at their site**	
		2 Meetings	10
		1 Meeting	5
		0 Meeting	0
5	20%	**Performance Measure: Cross Cohort Measure Pulmonary 02 (PUL 02) - percentage of patients with median tidal volumes less than or equal to 8 ml/kg (cumulative score January 1, 2020 through December 31, 2020)**	
		13 - 15 sites (out of 15 total sites) ≥ 90%	25
		13 - 15 sites (out of 15 total sites) ≥ 80%	15
		Less than 12 sites (out of 15 total sites) ≥80%	0
	30		
6	30%	**Performance Measure: Blood Pressure (BP 03) - Percentage of cases where intraoperative hypotension (MAP < 65 mmHg) was sustained for less than 15 minutes (cumulative score January 1, 2020 through December 31, 2020)**	
		Performance is ≥ 90%	25
		Performance is ≥ 85%	15
		Performance is ≥ 80%	10
		Performance is < 80%	0

2020 Anesthesiology Performance Improvement and Reporting Exchange (ASPIRE) Collaborative Quality Initiative Performance Index Scorecard POST COVID-19 Updates Cohort 1 - 4: 15 Sites (excludes Trinity sites) Measurement Period: 01/01/2020 - 12/31/2020			
Measure #	Weight	Measure Description	Points
7	20%	**Site Directed Measure: Sites choose a measure they are performing below national ASPIRE threshold by December 13, 2019 (cumulative score January 1, 2020 through December 31, 2020)**	
		Performance is ≥ 90%; 10% or 5%	20
		Performance is ≥ 80%; 15% or 10%	10
		Performance is < 80%; 15% or 10%	0

ASPIRE Cohorts 1-4 Summary of Changes:

- Measure #1: Adjusted to 2 Virtual meetings because MSQC / ASPIRE meeting was cancelled due to COVID
- Measure #4: Changed from 3 meetings to 2

All ASPIRE sites will receive full points for 2020 for Performance Measures (Measure #6)

2020 Anesthesiology Performance Improvement and Reporting Exchange (ASPIRE) POST COVID-19 Updates Collaborative Quality Initiative Performance Index Scorecard Cohort 5 - Year 1 (start 2020)			
Measure #	Weight	Measure Description	Points
1	20%	**Collaborative Meeting Participation: ASPIRE Quality Champion and Anesthesiology Clinical Quality Reviewer (ACQR) combined attendance at collaborative meetings. Two total virtual meetings with four opportunities for attendance.**	
		3 - 4 / 4 Virtual Meetings	20
		2 / 4 Virtual Meetings	10
		1 or Less Virtual Meetings	0
2	10%	**ASPIRE Champion or ACQR attend Monthly Webex ASPIRE Quality Committee Meetings**	
		5 Meetings	10
		4 Meetings	5
		3 or Less Meetings	0
3	10%	**Timeliness of Regulatory/Legal documentation: Business Associate Agreement (BAA), Data Use Agreement (DUA), Multicenter Perioperative Outcomes Group (MPOG) Bylaws & IRB**	
		Submitted by November 1, 2020	10
		Submitted by December 1, 2020	5
		Submitted after December 1, 2020	0
4	10%	**Hiring an ACQR**	
		ACQR Start Date on or before February 1, 2020	10
		ACQR Start Date on or before April 1, 2020	5
		ACQR Start Date on or after April 2, 2020	0
5	20%	**Timeliness of data submission (with Case by Case Validation and Data Diagnostic Attestations Completed)**	
		Data Submitted by November 1, 2020	20
		Data Submitted by December 1, 2020	10
		Data Submitted after December 2, 2020	0
6	20%	**Performance Metric: Accuracy of data of "High" and "Required" priority data diagnostics marked as "Data Accurately Represented" in Data Diagnostics Tool**	
		≥ 90% diagnostics marked as "Data Accurately Represented"	20
		≥ 75 - 90% marked as "Data Accurately Represented"	10
		< 75% marked as "Data Accurately Represented"	0

2020 Anesthesiology Performance Improvement and Reporting Exchange (ASPIRE) **POST COVID-19 Updates** Collaborative Quality Initiative Performance Index Scorecard Cohort 5 - Year 1 (start 2020)			
Measure #	Weight	Measure Description	Points
7	10%	**Timeliness of Responses to Coordinating Center Inquiry Requests**	
		Within 2 business days	10
		Within 5 business days	5
		Greater than 5 business days	0

ASPIRE Cohort 5 Summary of Changes:

- Measure #1: Changed from 3 meetings to 2 virtual meetings since the MSQC / ASPIRE meeting cancelled.
- Measure #3: Changed date from April to November due to COVID delays.
- Measure #5: Changed date from September to November to accommodate delays due to COVID.

All ASPIRE sites will receive full points for 2020 for Performance Measures (Measure #6)

2020 Anesthesiology Performance Improvement and Reporting Exchange (ASPIRE) Collaborative Quality Initiative Performance Index Scorecard POST COVID-19 Updates Trinity Sites: Mercy Muskegon, St. Joseph (Ann Arbor, Chelsea, Livingston, Oakland) and St. Mary Livonia Measurement Period: 01/01/2020 - 12/31/2020			
Measure #	Weight	Measure Description	Points
1	20%	**Collaborative Meeting Participation: ASPIRE Quality Champion and Anesthesiology Clinical Quality Reviewer (ACQR) combined attendance at collaborative meetings. Two total virtual meetings with four opportunities for attendance.**	
		3 - 4 / 4 Virtual Meetings	20
		2 / 4 Virtual Meetings	10
		1 or Less Virtual Meeting	0
2	10%	**Attend Webex ASPIRE Quality Committee Meetings: ASPIRE Quality Champion or ACQR attendance across five meetings**	
		5 Meetings	10
		4 Meetings	5
		3 or Less Meetings	0
3	5%	**Attend ACQR Virtual Retreat**	
		Yes	5
		No	0
4	20%	**Submit a complete set of files using File Checker software to Coordinating Center**	
		File Checker Submitted by July 1, 2020	20
		File Checker Submitted August 1, 2020	10
		File Checker Submitted after July 2, 2020	0
5	20%	**Timeliness of data submission (with Case by Case Validation and Data Diagnostic Attestations Completed)**	
		Data Submitted by December 31, 2020	20
		Data Submitted by January 1, 2021	10
		Data Submitted after January 2, 2021	0
6	10%	**Performance Metric: Accuracy of data of "High" and "Required" priority data diagnostics marked as "Data Accurately Represented" in Data Diagnostics Tool**	
		≥ 90% diagnostics marked as "Data Accurately Represented"	10
		≥ 75 - 90% marked as "Data Accurately Represented"	5
		< 75% marked as "Data Accurately Represented"	0
7	15%	**Timeliness of Responses to Coordinating Center Inquiry Requests**	
		Within 2 business days	15
		3 - 5 business days	10
		6 - 10 business days	5
		Greater than 10 business days	0

Summary of ASPIRE Changes (Trinity Hospitals)

- Measure #1: Changed to two virtual meetings since MSQC / ASPIRE Collaborative meeting was cancelled
- Measure #4: Changed date from June to July to allow for COVID delays
- Measure #5: Changed date from September to December 31, 2020 to allow for COVID delays
- Measure #6: Removed original Measure #6 to submit monthly provider e-mails because this will not be completed by the end of the year due to COVID.

2020 BCBSM Cardiovascular Consortium (BMC2) (Vascular Surgery Only) Revised Collaborative Quality Initiative Performance Index Scorecard Measurement Period: 01/01/2020 - 12/31/2020			
Measure #	Weight	Measure Description	VS Points
1	15	**2020 Meeting Participation - Clinician Lead**	
		2 Meetings	15
		1 Meeting	10
		Did not participate	0
2	15	**2020 Data Coordinator Expectations (Vascular Surgery: Includes 1-year follow-up ≥80%)**	
		Meets all expectations (1 Year FU ≥80%)	15
		Meets most expectations (1 Year FU 60-79%)	10
		Does not meet expectations (1 Year FU <60%)	0
5	20	**NEW -Vascular Surgery Collaborative Goal - Statin at Discharge for Open Bypass, CEA and CAS Discharges ≥ 95%**	
		≥95%	20
		<95% ≥93%	15
		<93% ≥90%	10
		<90%	0
6	25	**NEW - Vascular Surgery Performance Goal – Surgeons to prescribe a maximum of 10 opioid pills for opioid naïve patients with EVAR at discharge ≥ 70%**	
		≥70%	25
		<70% ≥65%	20
		<65% ≥60%	15
		<60%	0
7	25	**NEW - Vascular Surgery Performance Goal – Surgeons to prescribe a maximum of 10 opioid pills for opioid naïve patients with CEA at discharge ≥ 70%**	
		≥70%	25
		<70% ≥65%	20
		<65% ≥60%	15
		<60%	0

Summary of BMC2 Changes (VS Only)

- Measure #1: No change to scoring. Most meetings converted to webinar format.
- Measure #2: No change to scoring. No penalty for late submission, June data entry deadline.

2020 BCBSM Cardiovascular Consortium (BMC2) (PCI Only) Revised Collaborative Quality Initiative Performance Index Scorecard Measurement Period: 01/01/2020 - 12/31/2020			
Measure #	Weight	Measure Description	PCI Points
1	5	**2020 Meeting Participation - Clinician Lead**	
		3 Meetings	5
		2 Meetings	2.5
		Did not participate	0
2	5	**2020 Data Coordinator Expectations**	
		Meets all expectations	5
		Meets most expectations	2.5
		Does not meet expectations	0
3	10	**PCI Participation Goal - Internal Case Reviews**	
		Submitted reviews for ≥90% of cases	10
		Submitted reviews for <90% of cases	0
4	10	**PCI Participation Goal - Physicians Complete Cross Site Review of Assigned Cases for Procedural Indications and Technical Quality (based on 2018 cases)**	
		Submitted reviews for 100% of cases	10
		Submitted reviews for <100% of cases	0
8	17.5	**NEW - PCI Performance Goal: Peak Intra-Procedure ACT recorded**	
		≥80%	17.5
		<80% ≥70%	15
		<70% ≥60%	10
		<60%	0
9	17.5	**NEW - PCI Performance Goal - Percent of cases with peak ACT ≥350 seconds for Heparin-only cases**	
		≤25%	17.5
		>25% ≤35%	15
		>35% ≤45%	10
		>45%	0
10	17.5	**NEW - PCI Performance Goal - Percent of cases with peak ACT ≥300 seconds for Heparin+GPI cases**	
		≤25%	17.5
		>25% ≤35%	15
		>35% ≤45%	10
		>45%	0
11	17.5	**NEW - PCI Collaborative Goal - Lipid Lowering Agent prescribed at discharge**	
		≥98%	17.5
		<98% ≥94%	10
		<94%	0

Summary of BMC2 Changes (PCI Only)

- Measure #1: One in-person meeting was held in February. Additional 2 planned in-person meetings were replaced by 4 webinars. Total of 5 meeting opportunities in 2020.
- Measure #2: No change to scoring. Annual coordinator meeting converted to monthly webinars. No penalty for June data entry deadline.
- Measure #8: Target decreased by 10%, from ≥90% to ≥80%
- Measure #9: Target increased by 10%, from ≤15% to ≤25%
- Measure #10: Target increased by 10%, from ≤15% to ≤25%

2020 BCBSM Cardiovascular Consortium (BMC2) (PCI & Vascular Surgery) Revised Collaborative Quality Initiative Performance Index Scorecard Measurement Period: 01/01/2020 - 12/31/2020				
Measure #	Weight	Measure Description	PCI Points	VS Points
1	10	**2020 Meeting Participation - Clinician Lead**		
		2 Meetings	5	5
		1 Meeting	2.5	2.5
		Did not participate	0	0
2	5	**2020 Data Coordinator Expectations (Vascular Surgery: Includes 1 year follow-up ≥80%)**		
		Meets all expectations (1 Year FU ≥80%)	2.5	2.5
		Meets most expectations (1 Year FU 60-79%)	1	1
		Does not meet expectations (1 Year FU <60%)	0	0
3	5	**PCI Participation Goal - Internal Case Reviews**		
		Submitted reviews for ≥90% of cases	5	NA
		Submitted reviews for <90% of cases	0	NA
4	5	**PCI Participation Goal - Physicians Complete Cross Site Review of Assigned Cases for Procedural Indications and Technical Quality**		
		Submitted reviews for 100% of cases	5	NA
		Submitted reviews for <100% of cases	0	NA
5	12.5	**NEW -Vascular Surgery Collaborative Goal - Statin at Discharge for Open Bypass, CEA and CAS Discharges ≥ 95%**		
		≥95%	NA	12.5
		<95% ≥93%	NA	10
		<93% ≥90%	NA	5
		<90%	NA	0
6	10	**NEW - Vascular Surgery Performance Goal – Surgeons to prescribe a maximum of 10 opioid pills for opioid naïve patients with EVAR at discharge ≥ 70%**		
		≥70%	NA	10
		<70% ≥65%	NA	7.5
		<65% ≥60%	NA	5
		<60%	NA	0
7	10	**NEW - Vascular Surgery Performance Goal – Surgeons to prescribe a maximum of 10 opioid pills for opioid naïve patients with CEA at discharge ≥ 70%**		
		≥70%	NA	10
		<70% ≥65%	NA	7.5
		<65% ≥60%	NA	5
		<60%	NA	0

2020 BCBSM Cardiovascular Consortium (BMC2) (PCI & Vascular Surgery) Collaborative Quality Initiative Performance Index Scorecard Measurement Period: 01/01/2020 - 12/31/2020				
Measure #	Weight	Measure Description	PCI Points	VS Points
8	12.5	**NEW - PCI Performance Goal: Peak Intra-Procedure ACT recorded**		
		≥80%	12.5	NA
		<90% ≥80%	10	NA
		<80% ≥70%	5	NA
		<70%	0	NA
9	10	**NEW - PCI Performance Goal - Percent of cases with peak ACT ≥350 seconds for Heparin-only cases**		
		≤25%	10	NA
		>15% ≤25%	7.5	NA
		>25% ≤35%	5	NA
		>35%	0	NA
10	10	**NEW - PCI Performance Goal - Percent of cases with peak ACT ≥300 seconds for Heparin+GPI cases**		
		≤25%	10	NA
		>15% ≤25%	7.5	NA
		>25% ≤35%	5	NA
		>35%	0	NA
11	10	**NEW - PCI Collaborative Goal - Lipid Lowering Agent prescribed at discharge**		
		≥98%	10	NA
		<98% ≥ 94%	7.5	NA
		<94%	0	NA

BMC (PCI & VS) Summary of changes

- Measure #1: No change to scoring. Most meetings converted to webinar format.
- Measure #2: No change to scoring. Annual coordinator meeting converted to monthly webinars. No penalty for June data entry deadline.
- Measure #8: Target decreased by 10%, from ≥90% to ≥80%
- Measure #9: Target increased by 10%, from ≤15% to ≤25%
- Measure #10: Target increased by 10%, from ≤15% to ≤25%

2020 Michigan Hospital Medicine Safety Consortium Collaborative Quality Initiative Performance Index Scorecard **Revised Performance Index- COVID19 Pandemic** Measurement Period: 08/06/2020-11/11/2020 (PICC Insertions/Hospital Discharges)			
Measure #	Weight	Measure Description	Points
1	15	**Timeliness of HMS Data[1,8]**	
		On time ≥ 95%	15
		On time < 95%	0
2	15	**Completeness[1] and Accuracy[2,3] of HMS Data**	
		≥ 95% of registry data complete & accurate, semi-annual QI activity surveys completed, AND audit case corrections completed by due date	15
		< 95% of registry data complete & accurate, semi-annual QI activity survey not completed OR audit case corrections not completed by due date	0
3	20	**Consortium-wide Meeting Participation[4] – clinician lead or designee**	
		3 meetings[5]	20
		2 meetings	10
		1 meeting	0
		No meetings	0
4	20	**Consortium-wide Meeting Participation[4] – data abstractor, QI staff, or other**	
		3 meetings[5]	20
		2 meetings	10
		1 meeting	0
		No meetings	0
5	15	**PICC Quality Improvement**	
		Complete Steps 1-3 in PICC Tier II Toolkit in assigned complication group	15
		Steps 1-3 in PICC Tier II Toolkit not completed in assigned complication group	0
6	10	**Antimicrobial Quality Improvement- Guidelines[7]**	
		Submit UTI and pneumonia guidelines developed locally[6]	10
		Local UTI and pneumonia guidelines not submitted	0
7	5	**Antimicrobial Quality Improvement- Intervention Description[7]**	
		Submit a description of one intervention you have done, are doing or plan on doing for each • Decrease antibiotic treatment for patients with uncomplicated CAP to 5 days or less • Decrease treatment of ASB • Decreasing inappropriate Fluoroquinolone (FQ) use for UTI	5
		Description of interventions not submitted	0

2020 Michigan Hospital Medicine Safety Consortium Collaborative Quality Initiative Performance Index – Supporting Documentation

[1] Registry data assessed at year end based on data submitted during calendar year 2020. All required cases must be completed by year end. Final due date will be announced by Coordinating Center. Both semi-annual QI activity surveys must be completed by due dates announced by Coordinating Center.

[2] Assessed based on scores received for site audits conducted during calendar year 2020. Scores are averaged if multiple audits take place during the year.

[3] For audits conducted during the calendar year, audit case corrections must be completed or discrepancies addressed within 3 months of audit summary receipt (due date for case corrections provided in audit summary).

[4] Based on all meetings scheduled during calendar year 2020. Clinician lead or designee must be a physician as outlined in Hospital Expectations.

[5] The 3 Consortium Wide Meetings for 2020 include the following:

- July 29, 2020 Collaborative Wide Meeting (Virtual)
- October 1, 2020 Sepsis Symposium (Virtual)
- November 4, 2020 Collaborative Wide Meeting

[6] CAP Institutional guidelines should:

- Recommend 5-day antibiotic treatment duration for uncomplicated CAP
- Review the risk factors for multi-drug resistant organisms (MDRO) (i.e. provide guidance on when anti-pseudomonal and anti MRSA coverage is needed)
- Provide recommendations for transition to oral therapy
- De-emphasize fluoroquinolones

UTI Institutional guidelines should:

- Recommend against sending urine cultures in the absence of urinary symptoms
- Recommend against treating a positive urine culture in the absence of urinary symptoms
- De-emphasize fluoroquinolones
- Provide recommendations for transition to oral therapy

[7] In January 2021, HMS will distribute a survey to all abstractors/quality leads to obtain the information required for this measure. It is the abstractor/quality leads responsibility to work with key stakeholders who are involved with and lead the quality improvement work at each hospital related to the area of assessment.

[8] Case volumes for hospitals with submitted attestations during the COVID pandemic period defined by BCBSM **or** those participating in the Mi-COVID19 initiative at any time during the calendar year will not be factored into the total case volumes for this measure or will have adjusted case volumes dependent upon the date of their return to HMS abstraction (if applicable).

HMS Summary of changes:

- For measure #3 & #4, related to collaborative wide meeting participation, the list of meetings changed since the March 2020 Collaborative Wide meeting was cancelled due to the COVID pandemic. The Sepsis Symposium in October 2020 was added as a required meeting to replace the cancelled March meeting.
- Measures #5, #6, and #7 were changed from being based on performance to being based on participation, focusing on the effort that sites have put in to implement these quality projects.

2020 Integrated Michigan Patient-centered Alliance in Care Transitions (I-MPACT) Collaborative Quality Initiative **Performance Index Scorecard - I-MPACT Year 4/5 (Cohorts 1-4)** Measurement Period: 01/01/2020 - 12/31/2020			
Measure #	Weight	Measure Description	Points
1	5%	**Project Associate Only Conference Calls (Participation) - 3 calls required for 2020[1,2]**	
		Project Associate misses no more than 1/3 required calls for 2020.	5pts
		Project Associate misses no more than 2/3 required calls for 2020.	2pts
		Project Associate misses all 3 required calls for 2020	0 pts
2	5%	**Collaborative-wide Conference Calls (Participation) - 3 calls required for 2020[1,2]**	
		The cluster has at least one representative from each organization in the cluster, PLUS a Project Associate, present on 3/3 calls for 2020	5pts
		The cluster has at least one representative from each organization in the cluster, PLUS a Project Associate, present on 2/3 calls for 2020.	2pts
		The cluster has at least one representative from each organization in the cluster, PLUS a Project Associate, on <2 calls for 2020.	0 pts
3	5%	**Collaborative-wide meetings (Participation) - 2 meetings required for 2020[1,3]** *Clusters attending the June 2020 meeting will receive 2 bonus points on the 2020 P4P Index	
		The cluster has at least one representative from each organization in the cluster, PLUS a Project Associate, in attendance at all three meetings per calendar year.	5pts
		The cluster has at least one representative from each organization in the cluster, PLUS a Project Associate, in attendance at 2 of 3 meetings per calendar year.	2pts
		The cluster has at least one representative from each organization in the cluster, PLUS a Project Associate, in attendance at <2 of 3 meetings per calendar year.	0pts
4	5%	**Timely Submission of Data (Participation)**for clusters who submitted reassignment attestations, missing/late data abstracted March-June will not be penalized**	
		The required # of cases for the cluster is submitted on time 11 of 12 months.	5pts
		The required # of cases for the cluster is submitted on time 10 of 12 months.	3pts
		The required # of cases for the cluster is submitted on time <9 of 12 months.	0pts
5	10%	**Data Accuracy (Participation)**	
		Cluster achieves ≥ 90% accuracy on annual audit(s).	10pts
		Cluster achieves >80% but <90% data accuracy on annual audit(s).	5pts
		Cluster achieves <80% data accuracy on annual audit(s).	0pts
6	5%	**Intervention Deployment for target population (Participation)[4]**	
		Cluster implements and maintains interventions on 70% or > of the target population throughout 2020, as measured by registry data entered during January - May & October-December 2020. Excludes patients abstracted June-Sept (patients discharged March-June).	5pts
		Cluster fails to implement interventions in 70% or > of the target population in a minimum of throughout 2020, as measured by registry data entered during January - May & October-December 2020. Excludes patients abstracted June-Sept (patients discharged March-June).	0pts

2020 Integrated Michigan Patient-centered Alliance in Care Transitions (I-MPACT) Collaborative Quality Initiative **Performance Index Scorecard - I-MPACT Year 4/5 (Cohorts 1-4)** Measurement Period: 01/01/2020 - 12/31/2020			
Measure #	Weight	Measure Description	Points
7	5%	**Site Specific QI Log (Participation)**	
		Both QI logs completed/updated fully and submitted on time AND changes requested by I-MPACT CC submitted on time.	5pts
		1 or more QI logs completed/updated fully and submitted ≤7 calendar days past initial deadline and/or changes requested by I-MPACT CC submitted ≤7 calendar days past deadline.	2pts
		1 or more QI logs completed/updated fully and submitted >7 calendar days past initial deadline and/or changes requested by I-MPACT CC submitted >7 calendar days past deadline.	0pts
8	5%	**Patient/Caregiver Engagement (Participation)**	
		Cluster provides at least 2 NEW example of patient/caregiver advisor utilization/engagement on 1 or more QI log submissions (exclusive of advisors coming to collaborative-wide meetings or participating in monthly calls).	5pts
		Cluster fails to provide the required 2 new examples of patient/caregiver advisor utilization/engagement on 1 or more QI log submissions (exclusive of advisors coming to collaborative-wide meetings or participating in monthly calls).	0pts
9	25%	**Provider Follow-up Visits (Performance)** [5,6,9]	
		Based on data entered into the registry during January-May & October-December 2020, Cluster achieves the required 10% increase in follow-up appointments using the formula below[6], compared to the average from data entered during January-December 2019, unless 90% of all patients have follow-up appointments scheduled to occur within 7 days of discharge from the hospital; then at least 90% must be maintained.	25pts
		Based on data entered into the registry during January-May & October-December 2020, Cluster achieves ≥ 5% but < 10% of the required increase in follow-up appointments for the year, based on the formula below[6], compared to the average from data entered during January-December 2019.	15pts
		Based on data entered into the registry during January-May & October-December 2020, Cluster achieves < 5% of the required increase in follow-up appointments for the year, based on the formula below[6], compared to the average from data entered during January-December 2019 OR rate of PCP follow-up visits drops compared to the average from data entered during January-December 2019 OR once a cluster reaches 90% or greater, they fall below 90%.	0pts

2020 Integrated Michigan Patient-centered Alliance in Care Transitions (I-MPACT) Collaborative Quality Initiative **Performance Index Scorecard - I-MPACT Year 4/5 (Cohorts 1-4)** Measurement Period: 01/01/2020 - 12/31/2020			
Measure #	Weight	Measure Description	Points
10	15%	**Emergency Department Utilization (Performance)[7,9]**	
		Based on data entered into the registry during January-May & October-December 2020, Cluster achieves a 3% relative reduction in ED utilization in comparison to the average from data entered during January-December 2019 (ex. If ED utilization is 23% then a 3% relative reduction would be .69% resulting in a new ED utilization rate of 22.31%).	15pts
		Based on data entered into the registry during January-May & October-December 2020, Cluster achieves a ≥1.5 but <3% relative reduction in ED utilization in comparison to the average from data entered during January-December 2019 (ex. If ED utilization is 23% then a relative reduction of ≥1.5% but <3% would equal between .35% and .68% resulting in a new ED utilization rate between 22.65% and 22.32%).	7.5pts
		Based on data entered into the registry during January-May & October-December 2020, Cluster achieves a relative reduction <1.5% in ED utilization in comparison to the average from data entered during January-December 2019 OR ED utilization rate increases over the average for data entered during January-December 2019.	0pts
11	15%	**Readmission (Performance)[8,9]**	
		Based on data entered into the registry during January-May & October-December 2020, Cluster achieves a 3% relative reduction in 30-day all-cause readmission rates each year in comparison to the average from data entered during January-December 2019. (ex. If readmission rate is 23% then a 3% relative reduction would be .69% resulting in a new readmission rate of 22.31%).	15pts
		Based on data entered into the registry during January-May & October-December 2020, Cluster achieves a ≥1.5% but <3% relative reduction in 30-day all-cause readmission rates each year in comparison to the average from data entered during January-December 2019. (ex. If readmission rate is 23% then a relative reduction of ≥1.5% but <3% would equal between .35% and .68% resulting in a new readmission rate between 22.65% and 22.32%).	7.5pts
		Based on data entered into the registry during January-May & October-December 2020, Cluster achieves a relative reduction of <1.5% in 30-day readmission rates in comparison to the average from data entered during January-December 2019 OR readmission rate increases over the average for data entered during January-December 2019.	0pts

Summary of Changes to I-MPACT Measures (Cohorts 1-4):

- Measures #1 and #2: Reduced from 4 required calls to 3.
- Measure #3: Reduced from 3 meetings to 2 (Feb. & Oct.)
- Measure #4: Late/incomplete case volumes were excused from March through June for the 11 clusters who provided reassignment attestation forms, all other clusters will be held to the normal criteria
- Measure #6: Measure reduced from 80% to 70%
- Measure #8: Rather than requiring 2 new examples of patient engagement on each of the February and August logs, if a cluster provided two examples on either or both logs they will receive full points. 0 or 1 example(s) on either log is zero points.
- Measure #9: Rather than requiring clusters to increase their 2019 rates by 20% of the difference between 90% and their 2019 rates, they will be required to increase their rates by 10% of the difference between 90% and their 2019 rates. Data for patients discharged from March through June will be excluded from calculations due to most clinics being closed or seeing only urgent patients during that time.
- Measure #10: Rather than requiring clusters to decrease their 2019 rates by 5% compared to their 2019 rates, they will be required to decrease their rates by 3%. Data for patients discharged from March through June will be excluded calculations.
- Measure #11: Rather than requiring clusters to decrease their 2019 rates by 5% compared to their 2019 rates, they will be required to decrease their rates by 3%. Data for patients discharged from March through June will be excluded from calculations.

2020 Integrated Michigan Patient-centered Alliance in Care Transitions (I-MPACT) Collaborative Quality Initiative Performance Index Scorecard - I-MPACT Cohort 5 Measurement Period: 01/01/2020 - 12/31/2020			
Measure #	Weight	Measure Description	Points
1	7.5%	**Project Associate Only Conference Calls (Participation) - 3 calls required for 2020[1,2]**	
		Project Associate misses no more than 1/3 required calls for 2020.	5pts
		Project Associate misses no more than 2/3 required calls for 2020.	2pts
		Project Associate misses all 3 required calls for 2020	0 pts
2	7.5%	**Collaborative-wide Conference Calls (Participation) - 3 calls required for 2020[1,2]**	
		The cluster has at least one representative from each organization in the cluster, PLUS a Project Associate, present on 3/3 calls for 2020	5pts
		The cluster has at least one representative from each organization in the cluster, PLUS a Project Associate, present on 2/3 calls for 2020.	2pts
		The cluster has at least one representative from each organization in the cluster, PLUS a Project Associate, on <2 calls for 2020.	0 pts
3	10%	**Collaborative-wide meetings (Participation) - 2 meetings required for 2020[1,3]** *Clusters attending the June 2020 meeting will receive 2 bonus points on the 2020 P4P Index	
		The cluster has at least one representative from each organization in the cluster, PLUS a Project Associate, in attendance at all three meetings per calendar year.	5pts
		The cluster has at least one representative from each organization in the cluster, PLUS a Project Associate, in attendance at 2 of 3 meetings per calendar year.	2pts
		The cluster has at least one representative from each organization in the cluster, PLUS a Project Associate, in attendance at <2 of 3 meetings per calendar year.	0pts
4	10%	**Timely Submission of Data (Participation) **for clusters who submitted reassignment attestations, missing/late data abstracted March-June will not be penalized**	
		The required # of cases for the cluster is submitted on time 11 of 12 months.	5pts
		The required # of cases for the cluster is submitted on time 10 of 12 months.	3pts
		The required # of cases for the cluster is submitted on time <9 of 12 months.	0pts
5	10%	**Data Accuracy (Participation)**	
		Cluster achieves ≥ 90% accuracy on annual audit(s).	10pts
		Cluster achieves >80% but <90% data accuracy on annual audit(s).	5pts
		Cluster achieves <80% data accuracy on annual audit(s).	0pts
6	5%	**Intervention Deployment for target population (Participation)[4]**	
		Cluster implements and maintains interventions on 55% or > of the target population throughout 2020, as measured by registry data entered during January - May & October-December 2020. Excludes patients abstracted June-Sept (patients discharged March-June).	5pts
		Cluster fails to implement interventions in 55% or > of the target population in a minimum of throughout 2020, as measured by registry data entered during January-May & October-December 2020. Excludes patients abstracted June-Sept (patients discharged March-June).	0pts

2020 Integrated Michigan Patient-centered Alliance in Care Transitions (I-MPACT) Collaborative Quality Initiative Performance Index Scorecard - I-MPACT Cohort 5 Measurement Period: 01/01/2020 - 12/31/2020			
Measure #	Weight	Measure Description	Points
7	5%	**Site Specific QI Log (Participation)**	
		Both QI logs completed/updated fully and submitted on time AND changes requested by I-MPACT CC submitted on time.	5pts
		1 or more QI logs completed/updated fully and submitted ≤7 calendar days past initial deadline and/or changes requested by I-MPACT CC submitted ≤7 calendar days past deadline.	2pts
		1 or more QI logs completed/updated fully and submitted >7 calendar days past initial deadline and/or changes requested by I-MPACT CC submitted >7 calendar days past deadline.	0pts
8	5%	**Patient/Caregiver Engagement (Participation)**	
		Cluster provides at least 2 NEW example of patient/caregiver advisor utilization/engagement on 1 or more QI log submissions (exclusive of advisors coming to collaborative-wide meetings or participating in monthly calls).	5pts
		Cluster fails to provide the required 2 new examples of patient/caregiver advisor utilization/engagement on 1 or more QI log submissions (exclusive of advisors coming to collaborative-wide meetings or participating in monthly calls).	0pts
9	25%	**Provider Follow-up Visits (Performance)** [5,6,10]	
		Based on data entered into the registry during January-May & October-December 2020, Cluster achieves the required 10% increase in follow-up appointments using the formula below[6], compared to the average from data entered during January-December 2019, unless 90% of all patients have follow-up appointments scheduled to occur within 7 days of discharge from the hospital; then at least 90% must be maintained.	25pts
		Based on data entered into the registry during January-May & October-December 2020, Cluster achieves ≥ 5% but < 10% of the required increase in follow-up appointments for the year, based on the formula below[6], compared to the average from data entered during January-December 2019.	15pts
		Based on data entered into the registry during January-May & October-December 2020, Cluster achieves < 5% of the required increase in follow-up appointments for the year, based on the formula below[6], compared to the average from data entered during January-December 2019 OR rate of PCP follow-up visits drops compared to the average from data entered during January-December 2019 OR once a cluster reaches 90% or greater, they fall below 90%.	0pts

2020 Integrated Michigan Patient-centered Alliance in Care Transitions (I-MPACT) Collaborative Quality Initiative Performance Index Scorecard - I-MPACT Cohort 5 Measurement Period: 01/01/2020 - 12/31/2020			
Measure #	Weight	Measure Description	Points
10	15%	**Emergency Department Utilization (Performance)[7,10]**	
		Based on data entered into the registry during January-May & October-December 2020, Cluster achieves a 3% relative reduction in ED utilization in comparison to the average from data entered during January-December 2019 (ex. If ED utilization is 23% then a 3% relative reduction would be .69% resulting in a new ED utilization rate of 22.31%).	15pts
		Based on data entered into the registry during January-May & October-December 2020, Cluster achieves a ≥1.5 but <3% relative reduction in ED utilization in comparison to the average from data entered during January-December 2019 (ex. If ED utilization is 23% then a relative reduction of ≥1.5% but <3% would equal between .35% and .68% resulting in a new ED utilization rate between 22.65% and 22.32%).	7.5pts
		Based on data entered into the registry during January-May & October-December 2020, Cluster achieves a relative reduction <1.5% in ED utilization in comparison to the average from data entered during January-December 2019 OR ED utilization rate increases over the average for data entered during January-December 2019.	0pts

Summary of Changes to I-MPACT Measures (Cohorts 5):

- Measures #1 and #2: Reduced from 4 required calls to 3.
- Measure #3: Reduced from 3 meetings to 2 (Feb. & Oct.)
- Measure #4: Late/incomplete case volumes were excused from March through June for the 11 clusters who provided reassignment attestation forms, all other clusters will be held to the normal criteria
- Measure #6: Measure reduced from 80% to 70%
- Measure #8: Rather than requiring 2 new examples of patient engagement on each of the February and August logs, if a cluster provided two examples on either or both logs they will receive full points. 0 or 1 example(s) on either log is zero points.
- Measure #9: Rather than requiring clusters to increase their 2019 rates by 20% of the difference between 90% and their 2019 rates, they will be required to increase their rates by 10% of the difference between 90% and their 2019 rates. Data for patients discharged from March through June will be excluded from calculations due to most clinics being closed or seeing only urgent patients during that time.
- Measure #10: Rather than requiring clusters to decrease their 2019 rates by 5% compared to their 2019 rates, they will be required to decrease their rates by 3%. Data for patients discharged from March through June will be excluded calculations.

Revised 2020 MARCQI Collaborative Quality Initiative Performance Index Scorecard Measurement Period: 07/01/2019-06/30/2020 **OME Metric measurement period: 01/01/2020-06/30/2020**			
Measure #	Weight	Measure Description	Points
1	10	**Collaborative Meeting Participation-Clinical Champions (March 6, 2020 & October 9, 2020)**	
		2 out of 2 meetings attended	10
		1 out of 2 meetings attended	5
		0 out of 2 meetings attended	0
Extra Credit	0	***Extra credit*** Clinical champion attended June 26, 2020 Collaborative wide meeting and MAC	1
Extra Credit	0	***Extra credit*** Communication received by MARCQI Program Manager within 14 days of both furlough or redeployment attestation and return to work.	1
2	5	**Collaborative Meeting Participation-Clinical Data Abstractors (March 6, 2020 & October 9, 2020)**	
		2 out of 2 meetings attended	5
		1 out of 2 meetings attended	2.5
		0 out of 2 meetings attended	0
Extra Credit	0	***Extra credit*** Certified MARCQI CDA attended June 26, 2020 Collaborative wide meeting and CDA breakout	1
3	10	**Accuracy and Completeness of Data Submission (audits 7/1/19-6/30/20)**	
		Billing & Clinical audit score $\geq$ 97% **and** All 2019 case abstraction complete by October 5, 2020 **and** On December 31, 2020, all case abstraction must be complete for all surgeries done and prior to August 3, 2020	10
		Billing & Clinical audit score >85- <97% **and** All 2019 cases completely entered by October 5, 2020 A **or** On December 31, 2020, all case abstraction must be complete for all surgeries done and prior to August 3, 2020	5
		Incomplete 2019 and 2020 case entry. Billing & Clinical audit score <85%	0

Revised 2020 MARCQI Collaborative Quality Initiative Performance Index Scorecard Measurement Period: 07/01/2019-06/30/2020 OME Metric measurement period: 01/01/2020-06/30/2020			
Measure #	Weight	Measure Description	Points
4	5	**Site based Quality Meetings:(3/20-11/20)** **3 Site based quality meetings must occur following the 2020 MARCQI statewide meetings** to discuss surgeon, site based and collaborative outcomes with the orthopedic surgeons. **Exceptions were accepted following the March 6, 2020 MARCQI meeting with written documentation from hospital leadership prior to June 26, 2020.** The CDA and Clinical Champion participate in the discussion and development of Quality Improvement plans. The site will complete the 'Site Based QI Meeting' sign-in form and send minutes/agenda to the Coordinating Center before the next Collaborative meeting.	5
5	10	**% of Opioid naïve THA patients in the COLLABORATIVE meeting the MARCQI Pain Optimization Prescribing guidelines (≤240 OME) * 1/1/20-6/30/20**	
		75% or greater **o**f THA patients meet the guidelines of **240 OME** or less	10
		50-74% of THA patients prescribed **≤240 OME**	5
		Less than 50% of patients meet the prescribing criteria	0
6	10	**% of Opioid naïve TKA patients in the COLLABORATIVE meeting the MARCQI Pain Optimization Protocol Prescribing guidelines (≤320 OME)* 1/1/20-6/30/20**	
		75% or greater of TKA patients meet the guidelines of **320 OME** or less	10
		50-74% of TKA patients prescribed **≤320 OME** or less	5
		Less than 50% of patients meet the prescribing criteria	0
7	5	**% of Opioid naïve THA patients at the SITE meeting the MARCQI Pain Optimization Prescribing guidelines (≤240 OME) * 1/1/20-6/30/20**	
		75% or greater **o**f THA patients meet the guidelines of **240 OME** or less	5
		50-74% of THA patients prescribed **≤240 OME**	2.5
		Less than 50% of patients meet the prescribing criteria	0
8	5	**% of Opioid naïve TKA patients at the SITE meeting the MARCQI Pain Optimization Protocol Prescribing guidelines (≤320 OME)* 1/1/20-6/30/20**	
		75% or greater of TKA patients meet the guidelines of **320 OME** or less	5
		50-74% of TKA patients prescribed **≤320 OME** or less	2.5
		Less than 50% of patients meet the prescribing criteria	0
		Less than 50% of patients meet the prescribing criteria	0
9	20	**PROS Collection: Pre-op and post-op HOOS -JR or KOOS-JR + PROMIS (Overall average as of 12/31/2019. 2-16 week post-op accepted.)**	
		The site is awarded full points for collection rates of 60%+	20
		The site is awarded partial points for collection rates ≥35%-<60	10
		The site is not awarded points if collection is less than 35%	0

Revised 2020 MARCQI Collaborative Quality Initiative Performance Index Scorecard Measurement Period: 07/01/2019-06/30/2020 OME Metric measurement period: 01/01/2020-06/30/2020			
Measure #	Weight	Measure Description	Points
10	20	**Implementation of one site specific quality initiative (linked to a MARCQI quality initiative). If red on scorecard of April, 2019, you must choose this as the project. If no red, you will choose a 'yellow'. Progress Reports are due in May 2020 & January 2021. Final results are based on scorecard of January, 2021**	
		Plan submitted and: goal met *or* Case level dive into deviations complete, discussed, and reported	20
		Reporting requirements are met , but goal is not met or case level reporting not provided to coordinating center.	10
		Plan is not developed, reports not done.	0

MARCQI Summary of Changes:

- Measure #1 and #2: Reduced from 3 meetings to 2 meetings
- Extra credit measures added
- Measure #3: Added "All 2019 case abstraction complete by October 5, 2020" and "On December 31, 2020, all case abstraction must be complete for all surgeries done and prior to August 3, 2020" to receive full points
- Measure #4: Exceptions were accepted following the March 6, 2020 MARCQI meeting with written documentation from hospital leadership prior to June 26, 2020.
- Measure #9: Changed average as of "6/20/20" to average as of 12/31/2019
- Measure #10: Added "or Case level dive into deviations complete, discussed, and reported" to receive full points

2020 Michigan Bariatric Surgery Collaborative Collaborative Quality Initiative Revised Performance Index Scorecard			
Measure #	Weight	Measure Description	Points
1	15	**Grade 1 Complication:** (October 1, 2019-September 30, 2020) **Adjusted; Rounded to nearest whole number**	
		0% to ≤4% rate	15
		>4% to ≤6% rate	10
		>6% rate	0
2	10	**Serious Complication Rate:** (October 1, 2019-September 30, 2020) **Adjusted; Rounded to one decimal point**	
		0% to ≤2.4% rate	10
		>2.4% to ≤2.7% rate	5
		>2.7% rate	0
3	10	**Improvement/Excellence In Grade 1 Complication Rate:** (Data trended over a 3-yr period from October 1, 2017 to September 30, 2020) **Z-Score rounded to nearest whole number**	
		Major improvement (z-score less than -1 or Grade 1 complication rate ≤4%)	10
		Moderate improvement/maintained complication rate (z-score between 0 and -1)	5
		No improvement/rates of grade 1 complications increased (z-score ≥0)	0
4	10	**Improvement/Excellence in Serious Complication Rate:** (Data trended over a 3-yr period from October 1, 2017 to September 30, 2020) **Z-Score rounded to nearest whole number**	
		Major improvement (z-score less than -1 or serious complication rate ≤2.4%)	10
		Moderate improvement/maintained complication rate (z-score between 0 and -1)	5
		No improvement/rates of serious complications increased (z-score ≥0)	0
5	10	**1-Year Follow-up Rates** (For OR dates of October 1, 2018 to September 30, 2019) **Adjusted; Rounded to nearest whole number**	
		≥63% OR > 5% **relative** improvement from previous year (10/1/2017-9/30/2018)	10
		Maintained 1-year follow-up rate/ >0 to <5% relative improvement from previous year (10/1/2017-9/30/2018)	5
		1-year follow-up rate decreased/No improvement in 1-year follow-up rate (10/1/2017-9/30/2018)	0
6	2.5	**Compliance with VTE prophylaxis - Pre-operatively:**(Calendar Year 2020) **Unadjusted; Rounded to nearest whole number**	
		≥92% compliance with guidelines	2.5
		0 to 91% compliance with guidelines	0
7	2.5	**Compliance with VTE prophylaxis - Post-operatively:**(Calendar Year 2020) **Unadjusted; Rounded to nearest whole number**	
		≥91% compliance with guidelines	2.5
		0 to 90% compliance with guidelines	0

2020 Michigan Bariatric Surgery Collaborative Collaborative Quality Initiative Revised Performance Index Scorecard			
Measure #	Weight	Measure Description	Points
8	10	**Opioid Use - Opioid prescriptions within 30 days (measured in MMEs)** ***Collaborative wide measure, (October 1, 2019 to September 30, 2020)	
		≥ 10% relative reduction in opioid use	10
		5-9% relative reduction in opioid use	5
		< 5% relative reduction	0
11	5	**Timely Monthly Data Submissions (30-day information & registry paperwork):** (Submitted to coordinating center by the last business day of each month - Please refer to 2020 Data Entry Deadlines Spreadsheet) (Calendar Year 2020) *****In order to be eligible for this measure, you must achieve >90% on the 2020 yearly audit when applicable. If the hospital does not reach >90% for the yearly audit, they will receive 0 points for this measure.	
		On time 11-12 months	5
		On time 10 months	3
		On time 9 months or less	0
12	5	**Consent Rate:** (October 1, 2019 to September 30, 2020) **Unadjusted; Rounded to nearest whole number**	
		≥90% consented patients	5
		80-89% consented patients	3
		<80% consented patients	0
		Total	80

MBSC Summary of changes:

- Removed 2 Measures on meeting attendance- reducing the scorecard by 10 points (5 for clinical champion attendance, 5 for data abstractor attendance)
- Removed the physician engagement measure that accounted for 10 points
- Scorecard is now out of a total of 80 points instead of the previous 100 points

2020 Michigan Emergency Department Improvement Collaborative (MEDIC) Revised Quality Initiative Performance Index Scorecard - Year 1			
Measure #	Weight	Measure Description	Points
1	12	**Data Delivery: Timeliness** *Measurement Period: November 1, 2019 - February 29, 2020 and July 1, 2020 - October 31, 2020*	
		All data transfers on time	12
		75-99% of data transfers on time	6
		< 75% of data transfers on time	0
2	12	**Data Delivery: Adherence & Accuracy** *Measurement Period: November 1, 2019 - February 29, 2020 and July 1, 2020 - October 31, 2020*	
		All data transfers adhere to MEDIC data dictionary and are accurate	12
		75-99% of data transfers adhere to MEDIC data dictionary and are accurate	6
		< 75% of data transfers adhere to MEDIC data dictionary and are accurate	0
3	12	**Abstraction: Timeliness** *Measurement Period: November 1, 2019 - February 29, 2020 and July 1, 2020 - October 31, 2020*	
		All cohort cases abstracted within 30 days of load and/or ≤2 weeks worth of backlogged data	12
		75-99% of cohort cases abstracted within 30 days of load and/or > 2 weeks worth of backlogged data	6
		<75% of cohort cases abstracted within 30 days of load and/or >2 weeks worth of backlogged data	0
4	12	**Meeting Attendance: Clinical Champion** *Measurement Period: November 1, 2019 - October 31, 2020*	
		Attended 2 of 2 Collaborative-wide meetings	12
		Attended 1 of 2 Collaborative-wide meetings	6
		Attended 0 of 2 Collaborative-wide meetings	0
5	12	**Meeting Attendance: Data Abstractor** *Measurement Period: November 1, 2019 - October 31, 2020*	
		Attended 2 of 2 Collaborative-wide meetings	12
		Attended 1 of 2 Collaborative-wide meetings	6
		Attended 0 of 2 Collaborative-wide meetings	0
6	8	**Completion of Agreements (including but not limited to Participation Agreement, Business Associates Agreement, Data Use Agreement, and IRB if necessary)** *Measurement Period: 11/1/2019 - 10/31/2020 OR 11/1/2019 - 2/29/2020 and 7/1/2020 - 10/31/2020. Site will receive whichever score is better.*	
		Agreements signed and returned to MEDIC within 30 days of receipt	8
		Agreements signed and returned to MEDIC >30 days of receipt	0

2020 Michigan Emergency Department Improvement Collaborative (MEDIC) Revised Quality Initiative Performance Index Scorecard - Year 1			
Measure #	Weight	Measure Description	Points
7	12	**Time from Agreement being signed to hiring date of data abstractor** *Measurement Period: 11/1/2019 - 10/31/2020 OR 11/1/2019 - 2/29/2020 and 7/1/2020 - 10/31/2020. Site will receive whichever score is better.*	
		<90 days	12
		91-120 days	6
		>120 days	0
8	12	**Time from Agreements signed to successful submission of electronic production data** *Measurement Period: 11/1/2019 - 10/31/2020 OR 11/1/2019 - 2/29/2020 and 7/1/2020 - 10/31/2020. Site will receive whichever score is better.*	
		<90 days	12
		91-120 days	6
		>120 days	0
9	8	**Intervention Planning for Year 2, including PATH work (Intervention Templates, etc.)**	
		All Year 2 materials complete and submitted on time	8
		Year 2 materials incomplete and/or submitted late	0

MEDIC Year 1 Summary of Changes:

- Measures #1, #2, #3: Changed the measurement period to November 1, 2019 - February 29, 2020 and July 1, 2020 - October 31, 2020
- Measures #4 and #5: Number of collaborative wide meetings reduced to two.
- Measures #6, #7, #8: Changed timeline to November 1, 2019 - February 29, 2020 and July 1, 2020 - October 31, 2020. If the site began this process before March 1, 2020, and March 1, 2020 occurred prior to 90 days elapsing since the site received the agreements, the count of days paused as of February 29, 2020 and restarted July 1, 2020.

2020 Michigan Emergency Department Improvement Collaborative (MEDIC) Revised Quality Initiative Performance Index Scorecard- Year 2			
Measure #	Weight	Measure Description	Points
1	15	**Data Delivery: Timeliness** *Measurement Period: November 1, 2019 - February 29, 2020 and July 1, 2020 - October 31, 2020*	
		All 8 months of data transfers on time	15
		6-7 months of data transfers on time	10
		< 6 months of data transfers on time	5
2	15	**Data Delivery: Adherence & Accuracy** *Measurement Period: November 1, 2019 - February 29, 2020 and July 1, 2020 - October 31, 2020*	
		All 8 months of data transfers adhere to MEDIC data dictionary and are accurate	15
		6-7 months of data transfers adhere to MEDIC data dictionary and are accurate	10
		< 6 months of data transfers adhere to MEDIC data dictionary and are accurate	5
3	10	**Abstraction: Timeliness** *Measurement Period: November 1, 2019 - February 29, 2020 and July 1, 2020 - October 31, 2020*	
		All cohort cases abstracted within 30 days of load and ≤2 weeks worth of backlogged data	10
		75-99% of cohort cases abstracted within 30 days of load and/or > 2 weeks worth of backlogged data	5
		<75% of cohort cases abstracted within 30 days of load and/or >2 weeks worth of backlogged data	0
4	10	**Meeting Attendance: Clinical Champion** *Measurement Period: November 1, 2019 - October 31, 2020*	
		Attended 2 of 2 Collaborative-wide meetings	10
		Attended 1 of 2 Collaborative-wide meetings	5
		Attended 0 of 2 Collaborative-wide meetings	0
5	10	**Meeting Attendance: Data Abstractor** *Measurement Period: November 1, 2019 - October 31, 2020*	
		Attended 2 of 2 Collaborative-wide meetings	10
		Attended 1 of 2 Collaborative-wide meetings	5
		Attended 0 of 2 Collaborative-wide meetings	0
6	10	**Abstraction: Accuracy of Annual Data Audit** *Measurement Period: November 1, 2019 - October 31, 2020*	
		>97% of abstracted registry data accurate	10
		≤97% of abstracted registry data accurate	5

2020 Michigan Emergency Department Improvement Collaborative (MEDIC) Revised Quality Initiative Performance Index Scorecard- Year 2			
Measure #	Weight	Measure Description	Points
7	20	**Site Specific - Alternatives to Hospitalization Improvement Initiative** ***Measures and targets identified in Appendix** *Measurement Period: 11/1/2019 - 10/31/2020 OR 11/1/2019 - 2/29/2020 and 7/1/2020 - 10/31/2020. Site will receive whichever score is better.*	
		QI Project developed and implemented and site increased safe discharge rate for chosen condition relative to baseline	20
		QI Project developed and implemented but site did not increase safe discharge rate for chosen condition relative to baseline	15
		QI Project not developed or implemented	0
8	10	**Collaborative-Wide Measure: Minor Head Injury *Measures and targets identified in Appendix** *Measurement Period: 11/1/2019 - 10/31/2020 OR 11/1/2019 - 2/29/2020 and 7/1/2020 - 10/31/2020. Site will receive whichever score is better.*	
		Met Adult Minor Head Injury Target	5
		Met Pediatric Minor Head Injury Target	5
		Did not meet either target	0

MEDIC Year 2 Summary of Changes:

- Measures #1, #2, #3: Changed the measurement period to November 1, 2019 - February 29, 2020 and July 1, 2020 - October 31, 2020
- Measures #4 and #5: Number of collaborative wide meetings reduced to two.
- Measures #7 and #8:
    - New Measurement Timeframe: 11/1/2019 - 10/31/2020 OR 11/1/2019 - 2/29/2020 and 7/1/2020 - 10/31/2020. Site will receive whichever score is better.

2020 Michigan Emergency Department Improvement Collaborative (MEDIC) Revised Quality Initiative Performance Index Scorecard Years 3+			
Measure #	Weight	Measure Description	Points
1	5	**Data Delivery: Timeliness** *Measurement Period: November 1, 2019 - February 29, 2020 and July 1, 2020 - October 31, 2020*	
		All 8 months of data transfers on time	5
		6-7 months of data transfers on time	3
		< 6 months of data transfers on time	0
2	5	**Data Delivery: Adherence & Accuracy** *Measurement Period: November 1, 2019 - February 29, 2020 and July 1, 2020 - October 31, 2020*	
		All 8 months of data transfers adhere to MEDIC data dictionary and are accurate	5
		6-7 months of data transfers adhere to MEDIC data dictionary and are accurate	3
		< 6 months of data transfers adhere to MEDIC data dictionary and are accurate	0
3	5	**Abstraction: Timeliness** *Measurement Period: November 1, 2019 - February 29, 2020 and July 1, 2020 - October 31, 2020*	
		All cohort cases abstracted within 30 days of load and ≤2 weeks worth of backlogged data	5
		75-99% of cohort cases abstracted within 30 days of load and/or > 2 weeks worth of backlogged data	3
		<75% of cohort cases abstracted within 30 days of load and/or >2 weeks worth of backlogged data	0
4	5	**Meeting Attendance: Clinical Champion** *Measurement Period: November 1, 2019 - October 31, 2020*	
		Attended 2 of 2 Collaborative-wide meetings	5
		Attended 1 of 2 Collaborative-wide meetings	3
		Attended 0 of 2 Collaborative-wide meetings	0
5	5	**Meeting Attendance: Data Abstractor** *Measurement Period: November 1, 2019 - October 31, 2020*	
		Attended 2 of 2 Collaborative-wide meetings	5
		Attended 1 of 2 Collaborative-wide meetings	3
		Attended 0 of 2 Collaborative-wide meetings	0
6	5	**Abstraction: Accuracy of Annual Data Audit** *Measurement Period: November 1, 2019 - October 31, 2020*	
		>97% of abstracted registry data accurate	5
		≤97% of abstracted registry data accurate	3

2020 Michigan Emergency Department Improvement Collaborative (MEDIC) Quality Initiative Performance Index Scorecard Years 3+			
Measure #	Weight	Measure Description	Points
7	30	**Site Specific - Alternatives to Hospitalization Improvement Initiative** ***Measures and targets identified in Appendix** *Measurement Period: 11/1/2019 - 10/31/2020 OR 11/1/2019 - 2/29/2020 and 7/1/2020 - 10/31/2020. Site will receive whichever score is better.*	
		QI Project developed and implemented and site increased safe discharge rate for chosen condition relative to baseline	30
		QI Project developed and implemented but site did not increase safe discharge rate for chosen condition relative to baseline	20
		QI Project not developed or implemented	0
8	10	**Collaborative-Wide Measure: Minor Head Injury *Measures and targets identified in Appendix** *Measurement Period: 11/1/2019 - 10/31/2020 OR 11/1/2019 - 2/29/2020 and 7/1/2020 - 10/31/2020. Site will receive whichever score is better.*	
		Met Adult Minor Head Injury Target	5
		Met Pediatric Minor Head Injury Target	5
		Did not meet either target	0
9	30	**Site Specific - Quality Improvement Initiative *Measures and targets identified in Appendix** *Measurement Period: 11/1/2019 - 10/31/2020 OR 11/1/2019 - 2/29/2020 and 7/1/2020 - 10/31/2020. Site will receive whichever score is better.*	
		QI Project developed and implemented and site met or exceeded target	30
		QI Project developed and implemented and site made improvement to the target	20
		QI Project developed and implemented but there was no improvement to the target	10
		QI Project not developed or implemented	0

MEDIC Year 3 Summary of Changes:

- Measures #1, #2, #3: Changed the measurement period to November 1, 2019 - February 29, 2020 and July 1, 2020 - October 31, 2020
- Measures #4 and #5: Number of collaborative wide meetings reduced to two.
- Measures #7, #8, and #9: New Measurement Timeframe: 11/1/2019 - 10/31/2020 OR 11/1/2019 - 2/29/2020 and 7/1/2020 - 10/31/2020. Site will receive whichever score is better.

Michigan Radiation Oncology Quality Consortium (MROQC) Collaborative Quality Initiative 2020 Revised Performance Index Scorecard Measurement Period: 01/01/2020-09/30/2020			
Measure #	Weight	Measure Description	Points
1	10	**High Quality Clinical and Physics Data Submission[1]**	
		Four Metrics Met	10
		Three Metrics Met	8
		Two Metrics Met	4
		One Metric Met	2
		None Met	0
2	5	**Submission of Technical Data (Full DICOM-RT data and Physics Radiotherapy Technical Details Survey) *not accessed for cases with RT end dates from 3/1/2020-6/30/2020***	
		>85% of technical data submitted within six weeks of treatment completion	5
		>85% of technical data submitted within eight weeks	4
		>85% of technical data submitted within twelve weeks	3
		>85% of technical data submitted after twelve weeks	2
		<85% of technical data submitted after twelve weeks	0
3	14	**Collaborative-wide Measure: Omission of breast boost in women age 70 years or older with early-stage breast cancer[2]**	
		30% or fewer of select patients receive boost	14
		31-50% of select patients receive boost	7
		>50% of select patients receive boost	0
4	14	**Mean heart dose achieved in breast patients not receiving radiotherapy to regional nodes**	
		85% or more of patients meet the appropriate threshold[3]	14
		60-84% of patients meet the appropriate threshold	7
		<60% of patients meet the appropriate threshold	0
5	7	**For breast cancer patients: evaluate Task Group-263 compliance for the specified structures (heart, breast PTV, lumpectomy cavity PTV, and ipsilateral lung[4]) for the initial DICOM entry**	
		80% or greater compliance for the specified structures	7
		60-79% compliance for the specified structures	3
		<60% compliance for the specified structures	0
6	14	**For lung cancer patients, ≥ 95% of the Planning Target Volume (PTV) receives ≥100% of the prescription dose AND the heart mean dose is ≤20 Gray (Gy)**	
		65% or more patients meet target coverage and heart sparing goals	14
		50-64% of patients meet target coverage and heart sparing goals	7
		<50% of patients meet target coverage and heart sparing goals	0

Michigan Radiation Oncology Quality Consortium (MROQC) Collaborative Quality Initiative 2020 Revised Performance Index Scorecard Measurement Period: 01/01/2020-09/30/2020			
Measure #	Weight	Measure Description	Points
7	7	**For lung cancer patients: evaluate Task Group-263 compliance for the specified structures (heart, PTV, esophagus, spinal cord or canal, and normal lung[5]) for the initial DICOM entry**	
		50% or greater compliance for the specified structures	7
		30-49% compliance for the specified structures	3
		<30% compliance for the specified structures	0
8	14	**Rate of single fraction treatment of uncomplicated[6] bone metastasis**	
		>20% of patients with an uncomplicated bone metastasis are treated with a single fraction	14
		11-20% of patients with an uncomplicated bone metastasis are treated with a single fraction	7
		≤10% of patients with an uncomplicated bone metastasis are treated with a single fraction	0
9	5	**Meeting Participation – Clinical Champion (per MROQC CC Attendance Policy)***	
		Attended 2 of 2 collaborative wide meetings (second meeting - virtual attendance)	5
		Attended 1 of 2 collaborative wide meetings	3
		Attended 0 of 2 collaborative wide meetings	0
10	5	**Meeting Participation – Physics Lead (or designee)**	
		Attended 2 of 2 collaborative wide meetings (second meeting - virtual attendance)	5
		Attended 1 of 2 collaborative wide meetings	3
		Attended 0 of 2 collaborative wide meetings	0
11	5	**Meeting Participation – Clinical Data Abstractor (or designee)**	
		Attended 2 of 2 collaborative wide meetings (second meeting - virtual attendance)	5
		Attended 1 of 2 collaborative wide meetings	3
		Attended 0 of 2 collaborative wide meetings	0
	100		

MROQC Summary of Changes:

- Measure #2: Due to the pandemic, we will waive timeliness for cases with RT end dates between 3/1/20-6/30/20
- Measures #10 & #11: One collaborative wide meeting was canceled, and the other one was moved to virtual attendance. The number of collaborative wide meetings was reduced from 3 to 2.

Michigan Spine Surgery Improvement Collaborative 2020 Revised Collaborative Quality Initiative Performance Index Scorecard, Cohort 1, 2, 3 Measurement Period: 10/01/2019-09/30/2020, unless otherwise stated			
Measure #	Weight	Measure Description	Points
1	5%	**Meeting participation - Surgeon Champion**	
		Attended all 3 meetings	5
		Attended 2 out of 3 meetings	3
		Attended 1 out of 3 meetings	1
		No Attendance	0
2	3%	**Meeting and Abstractor Symposium participation – Clinical Data Abstractor. (If > 1 abstractor at site, only 1 abstractor need attend triannual meetings, however, <u>all</u> abstractors are required to attend the annual Abstractor Symposium)**	
		Attended all 4	3
		Attended 3 out of 4	2
		Attended 2 out of 4	1
		Attend 1 or none	0
3	5%	**Conference Calls Surgeon Champion (3 calls/year)**	
		Attended 3 calls	5
		Attended 2 calls	3
		Attended 1 call	1
		No Calls	0
4	3%	**Conference Calls - Clinical Data Abstractor (8 calls/year)**	
		Participate on 8 calls	3
		Participate on 7 calls	2
		Participate on 6 calls	1
		Participate on less than 6 calls	0
5	4%	**Meeting participation - Administrative Lead (no designee)**	
		Attend at least one triannual MSSIC meeting	4
		No Attendance	0
6	10%	**Annual Audit Review – Data Review: Accuracy of data -**	
		Complete and accurate 95-100% of the time	10
		Complete and accurate 90-94.9% of the time	5
		Complete and accurate < 90% of the time	0
For the remaining two performance measures below, **<u>we will calculate two scores</u>**: Score 1: Calculate performance using the original measurement period described in the original Performance Index (10/1/19-9/30/20). Score 2: Calculate performance using only pre-COVID, and post-COVID data (remove cases from 4/1/20-6/30/20). **<u>For each measure, sites will be given the best score</u>**			

Michigan Spine Surgery Improvement Collaborative 2020 Revised Collaborative Quality Initiative Performance Index Scorecard, Cohort 1, 2, 3 Measurement Period: 10/01/2019-09/30/2020, unless otherwise stated			
Measure #	Weight	Measure Description	Points
7	30%	**Collaborative-wide Measure Goal: MSSIC-All Early Ambulation - % of all spine patients (cervical and lumbar) with first ambulation within 8 hours of surgery stop time (rates rounded to the nearest whole number)**	
		MSSIC-All Early Ambulation 63% or greater	30
		MSSIC-All Early Ambulation 50-62%	20
		MSSIC-All Early Ambulation < 50%	0
8	40%	**Site Specific: Implementation of one Quality Improvement Initiative** using MSSIC data. If a site's lumbar SSI rate is > 2.0% for OR dates 7/1/18 – 6/30/19, they must choose lumbar SSI for their QI Initiative. Otherwise, they may choose a site-specific initiative approved by the Coordinating Center. The percentage goal of improvement is determined by the Coordinating Center. The time frame to establish a site's baseline rate is 7/1/18 – 6/30/19. The measurement period for improvement is 10/1/19-9/30/20.	
		The QI Plan was developed, implemented and the site met or exceeded their target goal. In addition, both QI Reports were submitted on time.	40
		The QI Plan was developed and implemented, and the site made improvement, but fell short of their target goal. In addition, both QI Reports were submitted on time.	30
		The QI Plan was developed and implemented, but there was no improvement to the target goal. In addition, both QI reports were submitted on time.	20
		The QI Plan was developed and implemented, but one of the QI reports was not submitted on time.	10
		The QI Plan was not developed or implemented; **or** both QI reports were not submitted on time.	0

MSSIC Summary of Changes:

- Remove two measures that previously measured baseline PROs (10 points) and post-operative PROs (10 points). Redistribute these points to other measures as described below.
- For the remaining two performance measures (Measure #7 and #8), MSSIC will calculate two scores. For each measure, sites will be given the best score.
    - Score 1: Calculate performance using the original measurement period described in the original Performance Index (10/1/19-9/30/20).
    - Score 2: Calculate performance using only pre-COVID, and post-COVID data (remove cases from 4/1/20-6/30/20).
- Measure #7
    - Measure used to be worth 20 points, now worth 30 points.

    - Collaborative wide target was previously 70% or greater for the full points, 54-69% for half points, and less than 54% resulted in 0 points. It is now 63% or greater for full points, 50-62% for half points, and less than 50% results in 0 points.
- Measure #8
    - Measure used to be worth 30 points, now worth 40 points.
    - Points were previously related to percentage of target goal achieved, but now the goal has shifted more to implementation with less focus on the specific goal amounts, but if any improvement was made.

2020 Michigan Surgical Quality Collaborative Revised Performance Index Scorecard Measurement Period: 01/01/2020- 12/31/2020			
Measure #	Weight	Measure Description	Points
1	8	**Collaborative Meeting (3) - Surgical Clinical Quality Reviewer (SCQR)**	
		3 meetings	8
		2 meetings	4
		1 meeting	0
2	8	**Collaborative Meeting (3) - Surgican Champion (SC)**	
		3 meetings	8
		2 meetings	4
		1 meeting	0
3	4	**Conference Calls (3) - SCQR**	
		2 or more calls	4
		1 call	2
		0 calls	0
4	4	**Conference Calls (3) - Surgeon Champion**	
		2 or more calls	4
		1 call	2
		0 calls	0
5	6	**Accuracy and Completeness of Data**	
		Biennial IRR with score ≥ 95%; OR if no IRR in current year, > 90% of eligible cases are captured on case upload for a targeted cycle	3
		Sampled and incomplete cases ≤ 0.5% total volume	3
6	20	**Collaborative Wide Measure - Increase Response Rate to PROs survey at 30 days post-surgery**	
		>45%	20
		40-45%	15
		35-39%	10
		<35%	0
7	50	**Quality Improvement Initiative**	
		90-100%	50
		80-89%	40
		70-79%	30
		60-69%	20
		50-59%	10
		<50% of total points earned on QII project	0

MSQC Summary of Changes:

- Measures #1 and #2:
  - The SCQRs will had a virtual training day on 6/19, and the SCs will have a presentation by Dr. Varghese on 6/25.
    - Participation in these events will replace the points offered for the March meeting that was cancelled. ○
    - Both of these presentations will be recorded.
    - Completion of the CME evaluation will be your proof of attendance, and will result in the award of Performance Index points.
    - Deadline for completing this process is July 31, 2020 to receive points.
  - Scheduled meetings on 10/2 and 12/4 will be held, but have not confirmed whether they will be held virtually or in person, virtual format is most likely at this time.
- Measure #7: The measurement period and scoring timeframe changes are detailed below:
  - Goal #1- Discharge Prescription with M-OPEN recommendations:
    - Measurement period changed to 7/1/20 – 12/31/20 (completed cases)
    - 10 points for each of the 2 selected procedure groups (Maximum points: 20)
  - Goal #2- Teaching and Multimodal
    - Measurement period changed to 7/1/20 – 12/31/20 (completed cases)
    - 5 points for each of the four metrics for the two selected procedure groups (Maximum points: 40)
  - Goal #3- Surgical Site Pain Score
    - Measurement period unchanged 4/1/20 – 12/31/20 (Maximum points: 20)
    - Clarified Goal: Maintain or increase the proportion of patients reporting mild (0-3) pain scores compared to baseline time period (4/1/2019-12/31/2019)
  - Goal #4- All Procedures Discharge Prescription
    - Measurement period 1/1/20 – 12/31/20 (Maximum points: 10)
  - Goal #5- Project Report: (Maximum points: 10)
    - Begin or continue tracking the work you are doing using the Tracking Sheet. This was updated with the new measurement periods and will need to be submitted with the education materials and order sets/practice model by 3/15/2021.

2020 Obstetrics Initiative Collaborative Quality Initiative Revised Performance Index Scorecard Measurement Period: 01/01/2020 - 12/31/2020			
Measure #	Weight	Measure Description	Points
1	5%	**MI AIM/ OBI Hospital Structure Survey**	
		Complete the 2019 MI AIM OBI Hospital Structure Survey	3.5
		Complete the 2020 MI AIM OBI Hospital Structure Survey	3.5
2	15%	**Attendance at the Fall OBI Collaborative-wide Meeting**	
		Fall SemiAnnual Collaborative Meeting Attendance- At least one Multistakeholder Team Member	
		November 6, 2020	6
		Fall SemiAnnual Collaborative Meeting Attendance- Clinical Data Abstractor (CDA) or Designee	
		November 6, 2020	6
3	30%	**Education**	
		Educational Webinar Attendance	
		At least three members of the Hospital team have watched 7 out of 10 webinars	12
		At least three members of the Hospital team have watched 5 out of 10 webinars	7
		At least three members of the Hospital team have watched 3 out of 10 webinars	3
		2020 Provider Education Webinar	
		Disseminate the OBI recorded Provider Education Labor Support webinar link to maternity care providers and Labor & Delivery (L&D) staff. > 80% of your maternity care providers and L&D staff have watched the recorded webinar by August 31, 2020	12
		Disseminate the OBI recorded Provider Education Labor Support webinar link to maternity care providers and L&D staff. 50-80% of your maternity care providers and L&D staff have watched the recorded webinar by August 31, 2020	7
		Disseminate the OBI recorded Provider Education Labor Support webinar link to maternity care providers and L&D staff. 20-49% of your maternity care providers and L&D staff have watched the recorded webinar by August 31, 2020	3
4	25%	**Hospital Engagement**	
		Culture Survey*	
		>50% Labor & Delivery (L&D) staff completed the culture survey by May 31, 2020	12
		>30% L&D staff completed the culture survey by May 31, 2020	7
		Made the Culture survey available in 2019 or committed to participate by the March 15, 2020 deadline	3

2020 Obstetrics Initiative Collaborative Quality Initiative Revised Performance Index Scorecard Measurement Period: 01/01/2020 - 12/31/2020			
Measure #	Weight	Measure Description	Points
		Peer-to-Peer Engagement: Video Workgroups	
		March 2020 Workgroup attendance by the team member whose workflow is most directly impacted by that month's subject.	4
		June 2020 Workgroup attendance by the team member whose workflow is most directly impacted by that month's subject.	4
		September 2020 Workgroup attendance by the team member whose workflow is most directly impacted by that month's subject.	4
		November 2020 Workgroup attendance by the team member whose workflow is most directly impacted by that month's subject.	4
5	15%	**2020 Clinical Data Abstractor Participation**	
		Timeliness and Completeness of Data Submission *	
		Submit the complete required case load of Term Singleton Vertex patients from October - December 2019 via OBI data registry by April 30, 2020.	5
		Submit the complete required case load of Term Singleton Vertex patients from January - March 2020 via OBI data registry by June 30, 2020.	5
		Submit the complete required case load of Term Singleton Vertex patients from April - June 2020 via OBI data registry by September 30, 2020.	5
		Submit the complete required case load of Term Singleton Vertex patients from July - September 2020 via OBI data registry by December 31, 2020.	4
6a	10%	**Implementation of Option A or B**	
		OPTION A: OBI CHECKLIST	
		Report implementation progress of the OBI Checklist by April 30th June 30th, September 30th, & December 31,2020 via OBI online portal.	10
		OR	
6b		**OPTION B: Promoting Spontaneous Progress in Labor Bundle**	
		Report implementation progress of the Spontaneous Labor Bundle by April 30th, June 30th, September 30th, & December 31, 2020 via OBI online portal.	10
TOTAL	100%		100

Summary of OBI Changes:

- Measures #2: March meeting removed from required attendance.
- Measure #3: Extended deadline for viewing from May 31st to August 31st
- Measure #4: Extended deadline from April 30th to May 31st
- Measure #6: Extended deadline from March 31st to April 30th, and added a December 31st report